New Choices Waiver
Incident Report Form

CLIENT'S NAME :	DOB: _____/_____/_____
FACILITY OF RESIDENCE NAME: (☐ N/A – not living in a facility)	DATE OF INCIDENT: TIME OF INCIDENT:
CLIENT'S MAILING ADDRESS:	
WAS THE FAMILY/RESPONSIBLE PERSON NOTIFIED? ☐ Yes ☐ No ☐ N/A	Does this client have a legal guardian? ☐ Yes ☐ No Guardian's name:___
LAW ENFORCEMENT NOTIFIED? ☐ Yes ☐ No ☐ N/A Date: _____ Case Number_____	APS NOTIFIED? ☐ Yes ☐ No ☐ N/A Date: _____

NARRATIVE DESCRIPTION OF INCIDENT

1. Location of incident:
2. What happened? (If reporting death, describe the cause and circumstances.)
3. How was it discovered?
4. Immediate actions taken:
5. Any precipitating events? (illnesses, medication changes, etc.)
6. Will there be any new safeguards as a result of this incident?

Please check the incident type below.

Any negative event must be reported to the case management agency (CMA) within 24 hours of discovery. The CMA must report any of the following types of incidents to the NCW Program Office within 24 hours of receiving notification:

In cases where the incident and/or the timing of reporting falls on a weekend or holiday, reporting the incident by the next business day is permissible.

☐ **Death, regardless of the circumstances**
☐ **Suicide attempt** (does not include threats only)
☐ **Incident expected to receive media, legislative or public scrutiny**
☐ **Compromised work or living environment requiring evacuation**
☐ **Person missing at least 24 hours or, regardless of the amount of time, missing under suspicious or unexplained circumstances** (Time of last known whereabouts: _____)
☐ **Injury** (includes burns, choking, brain trauma, fractures, etc.)
☐ **Abuse** (physical or sexual)
☐ **Neglect** (caregiver neglect or self-neglect)
☐ **Exploitation** (by somebody in a relationship of trust)
☐ **Waste, fraud, or abuse of Medicaid funds**
☐ **Human rights violation**
☐ **Medication/treatment errors resulting in marked adverse side effects** (includes inappropriate medication use while the medication is control of the provider, participant, or other individual)
☐ **Law enforcement involvement resulting in charges being filed**
☐ **Other type of incident causing concern for health and welfare**

Please answer the following 5 questions:

1. Did the person sustain an injury as a result of the incident? ☐Yes ☐No
2. Was the person treated in the ER and released the same day? ☐Yes ☐No
3. Was the person admitted to the hospital?
   ☐Yes ☐No
4. If 'yes' to #3, was the hospital admission directly related to the injury or was it for another medical reason or both?
   ☐Injury ☐Another medical reason ☐Both
5. Is/was the person receiving hospice care?
   ☐Yes ☐No

Provider Representative's Signature:	**Phone & Email:**	**Title:**	**Date forwarded to case manager:**
Case Manager's Signature:	**Phone & Email:**	**Date Notified:**	**Date forwarded to BACBS:**
BACBS Representative's Signature:	**Phone & Email:**	**Date Notified:**	**Date forwarded to SMA QA Unit:** ☐**N/A**